STATEMENT OF FINANCIAL CONDITION OF A PROSPECTIVE RESIDENT OF A COMMUNITY BASED RESIDENTIAL FACILITY (CBRF)

Completion of this form is required per s. 50.035(7), Wis. Stats. This form must be used for all prospective private pay residents and must be completed before a resident is initially admitted to a CBRF. Admission of Private Pay residents to a CBRF is prohibited without completion of this form.

NOTICE TO THE PROSPECTIVE RESIDENT

If you are considering residing in a Community Based Residential Facility (CBRF) and paying for the cost of your care with your own funds, please read this notice carefully. As a prospective resident of a CBRF you should be aware that public funding such as Medicaid, Medicare, the Community Options Program (COP) and other types of public funding may **not** be available to pay for the cost of your continued care in a CBRF if, in the future, you are no longer able to pay for your care. **You should also be aware that there are restrictions on the types and amount of government funding which can be used to pay for the cost of care in CBRFs, and that there are usually long waiting lists for these limited funds.** There are also special requirements to qualify for other types of care which may be paid for, in part, with government funding, such as home health care and nursing home care. **Before you become a resident of a CBRF, you should be aware that if you can no longer pay for the cost of your care, and government funding is not available to pay for your care, you would most likely be discharged from the CBRF because of unavailable funding.**

If you are not certain of your ability to pay for the cost of care in a CBRF for as long as necessary, you are advised to contact the county agency, in the county where the CBRF you intend to reside in is located, to obtain information about the restrictions of public funding for CBRF care, and other publicly funded care programs. You are urged to contact that county agency before you make a change in your current living arrangement. Please see the attached list of county agencies.

EXPLANATION OF THE STATEMENT OF FINANCIAL CONDITION

If you intend to pay for the cost of your care in a Community Based Residential facility (CBRF), Wisconsin Statutes require that you provide certain financial information to the CBRF prior to being admitted to the facility. The law is intended to help you determine how long you will be financially able to reside in the CBRF.

The CBRF will provide to you, on Part A of this form, an estimate of the *monthly* cost of your care at the time of admission to the facility, and the estimated cost for 24 months. Based on that estimate, you should indicate on Part A of this form whether you can pay for the cost of your care for "less than 24 months," or "24 months or more." If you estimate that you will be able to pay for your care for *less than 24 months*, the CBRF is required to provide a copy of this completed form to the county department of social services in the county where the CBRF is located.

Please note that Federal law related to Low Income Housing Tax Credit, which may apply to the CBRF to which you are considering admission, requires more detailed information about your finances than is required for this Wisconsin State form. A representative of the CBRF to which you are considering admission can advise you of this additional process if it applies to the CBRF,

PART A. STATEMENT OF FINANCIAL CONDITION

INSTRUCTIONS: To be completed by, or on behalf of the prospective resident.

Name of Prospective Resident	Date of Birth

Address			
City	**County**	**State**	**Zip Code**

The CBRF estimates the ***monthly*** cost of care, treatment and services to be:

$_____ x 24 months = $ _____
(CBRF to insert estimates)

Based on the above estimated cost of care, I have sufficient *available* income and/or assets to pay for the cost of my care for: (Check the item that applies to you.)

☐ less than 24 months. If you checked here, please estimate the number of months, 1 to 23, for which you can pay _____

☐ 24 months or more

EVIDENCE OF ABILITY TO PAY

Please provide the CBRF administrator with evidence that you have sufficient *available* income and assets to pay for the cost of your care for the period of time you indicated above. This evidence can be a signed letter from someone other than you who has knowledge of your income and assets such as your banker, accountant, lawyer, broker, power of attorney for finances, or the administrator of your trust, stating that you have sufficient income and/or assets to pay for your care for the time period indicated above. **If you choose to arrange for such a signed letter, then detailed financial information need not be provided to the CBRF for the purpose of this Wisconsin State form.** As an alternative to such a letter, you may choose to provide the CBRF administrator with a statement of your current income and assets. Your assets can be verified by providing a copy of your bank statement, brokerage statement, trust agreement, or a statement of other liquid assets; or evidence non-liquid assets and the estimated value of these assets available to pay for the cost of your care in the CBRF.

Available income and assets include, but may not be limited to, monthly income and liquid assets such savings account, checking account, certificates of deposit, stocks, bonds, and other liquid assets. Also included are non-liquid assets such as your home or other real estate, automobile(s), business, or other non-liquid assets, the equity or value of which would be available to you upon sale, or other conversion, to pay for the cost of your care.

Waiver of Confidentiality: Wisconsin Statutes specify that you waive your right to confidentiality of the information provided on this form only to the administrator of the CBRF, to the preparer of the information on this form if that person is someone other than yourself and, when applicable, to the county department of social services to which this form is sent. *All other information in this form, and any evidence of income and assets submitted to the CBRF as part of your Statement of Financial Condition, shall be kept confidential from all other persons except those persons expressly identified in this paragraph.*

(Please note that Section 50.03(2) of the Wisconsin Statutes, authorizes representatives of the Wisconsin Department of Health and Family Services, the state licensing agency for CBRFs, to make inspections of CBRFs and of records of CBRF residents. Therefore, Department representatives will also have access to the completed information on this form and any evidence of income and assets related to this form).

Signature _____ Date ____/____/____
Prospective Resident

Signature _____ Date ____/____/____
Person completing form for Prospective Resident

_____
Relationship to Prospective Resident

PART B. ESTIMATED MONTHLY COST OF CARE, TREATMENT AND SERVICES

INSTRUCTIONS: To be completed by the CBRF. A copy of the completed Parts A and B must be given to the prospective resident or their personal representative.

Name - CBRF	Capacity	Class

Address

City	County	State	Zip Code

ESTIMATED MONTHLY COST OF CARE

The CBRF hereby estimates that the total *monthly* cost of all care, treatment and services applicable to the prospective resident, at the time of admission is:

$ _____ per month X 24 months = $ _____

(NOTE: Insert these cost estimates in the spaces provided at the top of Part A on page 2 of this form.)

This cost estimate has been determined *after* the pre-admission assessment was completed by the CBRF.

The estimated date of admission to the CBRF is _____/_____/_____

SIGNATURE - CBRF Administrator	Date Signed

This estimate does not constitute a contract between the CBRF and the prospective resident.

ACTION BY THE CBRF

Check the applicable statement

☐ If the estimated length of time the person will be able to pay for his or her care is *less* than 24 months, the CBRF is required by Wisconsin Statute to provide a notice of that fact to the county agency in the county in which the CBRF is located, prior to the person being admitted to the CBRF. To fulfill this requirement, a copy of the completed form, Parts A and B, was sent to the county agency on _____/_____/_____ (date). See attached list of county agencies.

☐ The prospective resident's ability to pay for his or her cost of care is at least 24 months or more and a copy of this form was not sent to the county agency.

SIGNATURE - CBRF Administrator	Date Signed